Borck (Ed.)

WITH THE COMPLIMENTS OF THE AUTHOR.

OVARIAN TUMORS.

AT WHAT STAGE OF THE DISEASE IS IT THE PROPER TIME TO OPERATE?

BY

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AT WHAT STAGE OF THE DISEASE IS IT THE PROPER TIME TO OPERATE?

General rules have been laid down, it is true; and we must also admit, that every individual case must be considered upon its own merits. Emmet tells us (page 814) no inflexible rule can be laid down. But a judicious delay enables the peritoneum to become more tolerant of irritation and much less liable to inflammation than it would be were the tumor removed at an early stage of its growth; on the other hand, the patient may be deprived of all chances of recovery should the removal be delayed until the vital powers are so much depressed that she cannot react from the shock of the operation. This is a judicious precept, but unfortunately the latter is too often the case.

M. S. Dunlap, in a paper read before the Academy of Medicine of Paris (Oct. 20, 1878), says thus:

Relative to the period suitable to propose ovariotomy, I reject the early operation, and consider that it is indicated only when the cyst has become, by its volume, a source of excessive inconvenience to the patient, or when by local or general effects it becomes a cause of imminent danger to life.

Late ovariotomy, although it ought not to be adopted as a general rule, is nevertheless not contra-indicated by the gravest local and general complications, such as peritonitis, suppuration, gangrene of the cyst and extreme emaciation.

T. Spencer Wells tells us in Chap. 8 of his work, that medical treatment is of no avail, and I recommend every medical practitioner to read it carefully, and from page 261 I quote: "The question when surgical aid is really required, or how long a patient should be left to ordinary medical care, undisturbed by any surgi-

cal treatment, is one which is daily occurring in practice, and the answer should be framed upon some such common sense rule as the following:

As long as the patient does not suffer much pain, is not annoyed by her size and appearance, has no great difficulty in locomotion, does not suffer from injurious pressure on the organs of the chest, abdomen, or pelvis; and so long as the heart and lungs, digestive organs, kidneys, bladder and rectum perform their functions tolerably well, surgical treatment is seldom called for. Under ordinary circumstances the surgeon should not interfere until either of these symptoms are present, etc., etc."

Such advice as the above from so great and renowned a surgeon as T. Spencer Wells, certainly commands all due consideration by all who are interested, but should not be carried into extremes, as it is too often done.

Directly opposite opinions are held, whether to operate in full health or to defer till it is impaired.

Peaslee tells us that (in 1864) Wells, Black, Brown, held, that the more robust the patient is, the better. Hutchinson maintained that the earlier we operate the better, so does Spiegelberg, of Breslau. Brown operates as soon as the diagnosis is established Bryant, Clay, and others hold the same views.

Atlee, Bradford, Smith, Keith and Erichson think the results of the operation are more favorable if the general health is somewhat impaired by the ovarian disease, and Peaslee agreed with them.

Dr. W. T. Briggs, the renowned surgeon of Nashville, Tenn., does not believe in the recommendation of waiting until the patient is about to die; he operates early, as early as a diagnosis is made, if his patient submits, and while she is still strong, then she can stand the operation better; he saves about 66 per cent. and believes in Lister's antiseptic method.

Dr. I. A. Ireland, a distinguished surgeon of Louisville, Ky., believes also in early operations, before the system is broken down, and life well nigh extinguished, for after this success must always be bad. He feels satisfied that a woman's chance is much better if she is determined to get well. The mind has a wonderful influence over the body, and the want of success depends more upon climate and other surroundings, than upon the operator.

There is no doubt when that stage of the disease has arrived, when the general health *is threatened* to be impaired, that it is the best time for the largest number of recoveries to be obtained by operation. This, however, is a very nice and delicate point to be decided.

But unfortunately, as a rule, the patient does not come under the surgeon's care at that stage of development, it is generally a

good deal later, the prospect is not as favorable, it is much worse or even desperate.

I have seen and examined within the last two years a large number of ovarian tumors, and out of every ten cases, I have not been able to find one that might be called very favorable, at least not a single one of all the cases that I saw, was at that stage indicated as so favorable, by Peaslee, they were all far beyond that stage. The story of the patient was invariably that she has been advised by her own family physician and others that had been consulted, to wait, wait! wait until the last moment, wait until she could not walk, nor eat and drink, nor breathe, nor evacuate her bowels, or bladder, nor enjoy a good night's sleep ; the patients had been constantly impressed with the great danger of the operation, until at last most all her courage has failed, and the slightest allusion to the knife was dreaded.

Such seems to me has been the theory and method adopted in the city and vicinity where I reside. The patients seem to prefer to live as long as they can in misery and distress, rather than to submit to a timely operation and run a little risk. A little more encouragement, a little more hope held out, and thus prepare the mind in time to get accustomed to the idea of an unavoidable operation, I surely believe would be wiser, more beneficial to the patient; instead of this, discouragement and waiting, as a rule, have been kept up until the patient at last gives up in dispair, loses all hope, her nervous system shattered, general constitution broken down, the prospect for a successful operation very, very faint; the case is then turned over to the surgeon, and of him it is expected not to shrink from his duty; even in a desperate case to give the patient a last chance, with the faintest hope of success, she and the relations perhaps accept the situation with the full understanding of the danger on her side, and submit or desire the operation as a last resort; the surgeon inspired with a sense of his duty, operates, gives all the care and attention possible, but will most likely lose his patient; to refuse to operate in these desperate cases for fear of increasing the surgeon's death rate, would indicate a want of courage, would not be human; and not to make known the unsuccessful cases to the profession, a want of moral courage. To select the good and favorable cases only, is, in my estimation, certainly not manly, we must take them as they come. I have seen these cases treated by more than one admirable physician, with drastic purgatives and other drugs, and they fancied that their patients were getting better, that is, thinner; the latter is true, the patient becomes thinner, but not the tumor. If some ascitic fluid is present, it may possibly be removed by drugs, ovarian fluid never; there is no drug known to me that does it.

As long as the tumor keeps on increasing, the rest of the body will decrease; if the tumor has grown so large as to disturd the general functions, and especially impair the digestive process, inanition must follow, and no treatment short of removal of the mechanical obstruction will do any good, do what you may. Again, some will argue, that as long as the patient does not lose in weight, operative interference is unnecessary. Let us take a case for illustration, a person weighs 140 pounds, an ovarian tumor begins to make its appearance, weigh her from time to time, the weight is still 140 pounds, tumor increasing to a large size, weigh her again she may still weigh 140 pounds; say that of this weight the tumor weighs 40 pounds, she still holds her own, the rest of the body weighs but 100 pounds. Has the patient not lost in weight? and will she not lose more the larger the tumor grows? and it will not take long before she goes far below her natural weight; let that not be forgotten, do not be deceived by the weight.

The argument in favor of waiting we have learned from what has been said. The main favorable points of delaying the operation seems to be the peritoneum, so that it may become less sensitive and less liable to traumatic peritonitis, for peritonitis destroys ¾ of all cases, (T. G. Thomas, 4 ed). Next is hemorrhage, which is claimed less liable to occur in anemic than in robust patients. And here let me remark: That polycyst will terminate fatally in twelve months after the third stage has begun; oligocysts in about twenty-four months. The first grows more rapidly and demands earliest interference, within about 1 year; the second within 1½—2 years. The average duration of life after the cysts have developed is about four years; according to Lee, two years.

Now, the deduction that I can make from the above and from the reported cases of others, and my own, is, that it would be better to recommend the operation rather a little too soon than too late, and that the early operation will be the accepted rule in the future, for the following reasons:

1st. That abdominial section is by far not so dangerous under the antiseptic method, as prior to this, without it. Peritonitis is thereby claimed to be prevented, and we are informed by good authority that we now can operate at least one year sooner. Observe the success Shrœder and others had since they adopted the antiseptic method. (See also Nathan Bozeman's remarks on Ovariotomy, *N. Y. Med. Record*, July and August, 1878).

2d. As the peritoneal cavity has been opened and exposed in other operations, without peritonitis following, and where waiting for distention was out of the question. For Dr. Martin, of Berlin, has removed five times a floating kidney, four times successfully by abdominal section. Marian Sims tells us that his operations before Listerism would have been wholly unjustifiable.

So the danger of traumatic peritonitis is greatly reduced by Listerism, and the argument that in anemic patients the danger of secondary hemorrhage is not so likely to occur, seems to me not very solid, though it is true where there is no blood none can flow. I myself should prefer rather a little too much blood than too little, too much we can easily reduce, and we can control a too rapid flow of blood by contracting the blood vessels by ergot, and may thereby prevent oozing. But where there is too little, more is hard to be produced.

Six times vaginal ovariotomy has been performed in this country, all early operations and successfully. The first I believe by T. G. Thomas, though it is not his belief that the scope of this plan will ever be very great. But I myself believe a good deal speaks in its favor.

In conclusion I would say, that the object of this communication is to call attention to the above arguments, and especially to the inadvisability recommended, waiting or delaying the operation.

A judicious delay may be beneficial, a too long delay will do harm. I think that with our present stage of knowledge and facilities, the early operation would be preferable.

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